DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION JUN 28 2002

1. TRANSMITTAL NUMBER: **02-007**

2. STATE: **Alaska**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
05-01-02

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Title XIX Sec. 1927d5; USC Sec 1396r-8

7. FEDERAL BUDGET IMPACT:
a. FFY 02 $ <256,517.79>
b. FFY 03 $ <500,812.75>

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attached page to Attachment 3.1 A, pages 1-6

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attached page to Attachment 3.1A, pages 1-6

10. SUBJECT OF AMENDMENT:
Prior authorization requirement for certain drugs.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Jon Lywood per

13. TYPED NAME: Bob Labbe

14. TITLE: Director

15. DATE SUBMITTED: June 25, 2002

16. RETURN TO:
Division of Medical Assistance
P.O. Box 110660
Juneau, Alaska 99811-0660

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: JUN 28 2002

18. DATE APPROVED: DEC 23 2002

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:
/S/

21. TYPED NAME: Bunnee A. Butterfield

22. TITLE: Acting Associate Regional Administrator

23. REMARKS:

"POSTMARKED: 6/25 (DATE) • Juneau (CITY/STATE)

FORM HCFA-179 (07-92)

Description of Service Limitations

1. **INPATIENT HOSPITAL SERVICES:** All hospitalization must be physician prescribed. Hospital length of stay is limited to the 50th percentile of the LOS (length of stay) study for western states for the particular primary or surgical diagnosis involved, except psychiatric admissions authorized by the division's utilization review contractor, and maternal and newborn hospital stays related to childbirth which are limited to 48 hours of inpatient stay for a normal vaginal delivery and 96 hours of inpatient stay for a cesarean delivery. Selected surgical procedures and selected medical diagnoses require preadmission certification from the Provider Review Organization (PRO). Hospitals must secure continued stay authorization from PRO when a recipient's hospital confinement reaches the 50th percentile length of stay and, thereafter, at intervals prescribed by PRO.

   Organ transplants must be prior authorized by the division or its designee. Coverage for organ transplants is limited to kidney, corneal, skin, bone, and bone marrow transplants for adults and children under 21; liver transplants for adults and children under 21 with biliary atresia or other form of end-stage liver disease; and heart transplants for children under 21. Coverage for transplants also extends to coverage for outpatient immunosuppressive therapy. Organ transplants and requisite related medical care will be covered at an available transplant center either within the state or at a transplant center located outside the state that has been authorized by the division.

2. a. **OUTPATIENT HOSPITAL SERVICES:** "Outpatient hospital services" excludes services not generally furnished by most hospitals in the state, such as outpatient psychiatric and substance abuse treatment services.

3. **LABORATORY AND X-RAY SERVICES:** Laboratory and X-ray services must be ordered by a physician. Medically necessary diagnostic mammograms are covered. Screening mammograms are covered at the age and frequency schedule of the American Cancer Society, as provided in state statute.

4. a. **NURSING FACILITY:** Placement in a nursing facility providing a skilled level of nursing care requires prior authorization by the Division of Medical Assistance.

4. b. **EPSDT -- ENHANCED SERVICES:**

   (1) Private duty nursing services are limited to children who are either recently discharged from or admissible to an acute care or long-term-care facility. Services must be prior authorized; provided by a private nursing agency, a home health agency, or a hospice agency, must be less than 24 hours per day; and, when combined with the other Medicaid services the child uses, cannot exceed the cost of institutionalization.

   (2) Podiatry services are limited to services prescribed by a physician that relate to a specific condition of the ankle or foot.

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(3) Nutrition services are provided to children who meet the department's list of conditions
that place the recipient at high risk nutritionally. Nutrition services are limited to one assessment and 12 visits in any 12-month period unless additional service is prior authorized.

(4) Chiropractic services are provided to recipients under age 21, are limited to 12 treatments consisting of manual manipulation to correct a subluxation of the spine, and one x-ray code per recipient per year. Children under six years of age must be prior authorized by the medical review section of the Division of Medical Assistance before chiropractic services are rendered.

(5) Dental services for children are covered as specified in federal regulations (42 CFR 441.56) governing EPSDT when provided by a licensed dentist, including an orthodontist.

(6) Emergency hospital services, as defined in 42 CFR 440.170, are covered only for recipients under age 21.

4. c. **FAMILY PLANNING SERVICES:** Fertility services are not covered.

5. a. **PHYSICIAN SERVICES:** A surgical procedure that could be considered experimental, investigative, or cosmetic is not covered, unless that procedure is medically necessary in the course of treatment for injury or illness and has been prior authorized by the medical review section of the Division of Medical Assistance.

6. b. **OPTOMETRISTS SERVICES:** Vision services are provided to recipients experiencing significant difficulties or complaints related to vision or if an attending ophthalmologist or optometrist finds health reasons for a vision examination. A second vision exam in a 12-month period must be prior authorized.

6.d. **DIRECT ENTRY MIDWIFE SERVICES:** Direct entry midwife services are those services for the management of prenatal, intrapartum and postpartum care that a direct entry midwife is authorized to provide under the scope of practice of her state license.

7.a-d. **HOME HEALTH SERVICES:** Home health services must be requested by the attending physician and must be prior authorized by the medical review section of the Division of Medical Assistance or its fiscal agent.. Occupational therapy, physical therapy, and speech pathology/audiology may be ordered by a physician, advanced nurse practitioner, or other licensed health care professional within the scope of the practitioner's license.

c. Equipment and appliances that require prior authorization by the medical review section of the Division of Medical Assistance or its fiscal agent are listed in the physician provider manual.

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9. **CLINIC SERVICES:** "Clinic Services" means services provided by state-approved outpatient community mental health clinics that receive grants under AS 47.30.520--47.30.620, state-operated community mental health clinics, and mental health physician clinics. Ambulatory surgical clinic services and renal disease physician clinics are provided as separate services.

10. **DENTAL SERVICES:** Dental services for recipients age 21 and older are limited to emergency treatment for the relief of pain and acute infection.

11.a-c. **PHYSICAL THERAPY AND RELATED SERVICES:** Physical therapy, occupational therapy and speech pathology/audiology services are provided upon the order of a physician, advanced nurse practitioner, or other licensed health care professional within the scope of the practitioner's license.

12.a. **PRESCRIBED DRUGS AND DEVICES:**

(1) The following prescribed drugs are included:

(a) drugs, which require a prescription, except for those drugs specifically excluded;

(b) a compounded prescription, provided that at least one ingredient requires a prescription for dispensing;

(c) except for a recipient in a long term care facility or an intermediate care facility for the mentally retarded, a drug that has been prescribed even if that drug may be sold without a prescription:

(i) laxatives and bismuth preparations;
(ii) vaginal antifungal creams and suppositories;
(iii) prenatal vitamins for pregnant and nursing women;
(iv) nonoxynol 9 contraceptive creams, foams, gels, and sponges;
(v) respiratory saline products;
(vi) bacitracin ointment;
(vii) ferrous sulfate and ferrous gluconate in non-sustained release forms; and
(viii) debrisin and compounds for decubitus ulcers that contain sugar, provide iodine, or aluminum chlorhydrate;
(ix) insulin and insulin syringes;

(d) growth hormones, if prior authorization has been obtained from the division, and only if they are prescribed for a medically accepted indication for the treatment of children.

(2) Certain other drugs, not otherwise specifically excluded from payment, may be covered only after prior authorization has been obtained from the Division. These drugs may be further limited on the minimum or maximum quantities per prescription or on the number of refills to discourage waste and address instances of fraud or abuse by individuals. The Division will ensure a response to each prior authorization request is provided within 24 hours. In emergency situations, at least a 72-hour supply of the covered outpatient prescription may be dispensed.

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(3) The following drugs are not covered:
(a) drugs used to treat infertility, obesity, and for cosmetic purposes;
(b) drugs that are prohibited from receiving federal Medicaid matching funds under 42 CFR 441.25, as amended October 1, 1981;
(c) drugs, except for birth control drugs and drugs listed in 12. a. (a)(1)(c) of this attachment if dispensed in an unopened container, for which more than a 30-day supply is ordered per prescription;
(d) smoking cessation products;
(e) drugs used for the symptomatic relief of coughs and colds;
(f) oral vitamins, except prenatal, fluoride preparations, folic acid, Vitamin A, Vitamin K, Vitamin D, and analogs; and
(g) brand name multi-source drugs when a therapeutically equivalent generic drug is on the market unless the prescriber writes on the prescription "The brand name drug is medically necessary" and states the reason for the brand name drug's medical necessity.

12 c. Prosthetic devices are provided upon a physician's order.

12 d. Eyeglasses are provided to recipients in response to an initial or change of prescription, or as a replacement of a lost or destroyed pair of glasses. Tinted lenses are not covered unless medically necessary. Contact lenses are not covered except for specific medical conditions. Tinted lenses and contact lenses must be prior authorized. Eyeglasses are purchased for recipients under a competitively bid contract.

13. **DIAGNOSTIC, SCREENING, PREVENTIVE, REHABILITATIVE SERVICES:**

a. Mammography coverage is limited to diagnostic mammograms necessary to detect breast cancer.

b. Screening mammograms are covered at the age and frequency schedule of the American Cancer Society, as provided in state statute.

d. Rehabilitative Services are limited to the following:

(1) Mental Health Rehabilitative Services

(i) For children under 21 years of age, who have been found by an EPSDT screen/mental health assessment to need:

(A) Crisis Intervention Services, which consist of medically necessary reimbursable services below during an acute episode, including such services as assessment, psychotherapy, and medication management, limited to 22 hours in a calendar year and no more than one hour per day;

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(B) Family, individual, or group psychotherapy, with an overall aggregate limit of 10 sessions in a calendar year unless prior approval is granted;

(C) Intake Assessment, a systematic evaluation of status and history, limited to 3 hours per assessment and no more than 1 assessment per admission;

(D) Medication management, limited to one visit per week for the initial month and once per month thereafter, unless medical justification exists for greater frequency, and no more than 15 visits in a calendar year;

(E) Psychiatric assessment, a systematic evaluation by an MD or psychiatric nurse practitioner, limited to four per recipient in a calendar year unless prior approval is granted;

(F) Psychological testing and evaluation by a psychologist or psychological associate, must be prescribed in an assessment and is limited to 6 hours per recipient in a calendar year, excepting neuro-psychological testing and evaluation is limited to 12 hours in a calendar year upon prior approval;

(G) Home-based therapy, otherwise-reimbursable mental health services such as psychotherapy, when found necessary by an interdisciplinary team, (IDT) and limited to 100 hours in a calendar year unless prior approval is granted;

(H) Activity therapy, including rehabilitative teaching of life skills, when found necessary by an IDT, and limited to 140 hours in a calendar year unless prior approval is granted;

(I) Day Treatment Services, consisting of psychotherapy and/or activity and home-based therapies, when found necessary by an IDT, and limited to 30 full or 60-half days of service in a calendar year, unless prior approval is granted;

(J) Intensive Rehabilitation Services, consisting of one or more of the services above, when found to be necessary by an inter-departmental team, and limited to 90 days unless prior approval is granted;

(K) Medication Administration Services, consisting of administration of injectable or oral psychotropic medications to a recipient of other mental health rehabilitation services, limited to no more than one visit per week for the initial month, and then no more than 15 visits in any calendar year.

The services above must be specified in an individual plan of care; limits specified in A-F may be exceeded only upon an IDT determination of medical necessity and prior

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approval is granted by the division or its designee; and providers must be approved by the Division of Mental Health and Developmental Disabilities. Family Support Services (Supplement 1 to Attachment 3.1-A) are limited to 15 hours per month, 180 hours in a calendar year unless prior approval is granted.

(ii) For adults who have been found in a treatment plan signed by a physician or a mental health professional clinician to need:

(A) Psycho-Social Development (or "day treatment"), the strengthening of behavioral, intellectual, and emotional skills necessary to regain independence, to a maximum of four hours per day, 3 days per week, and no more than 240 hours in a calendar year; and

(B) Intensive Rehabilitation Services, consisting of one or more of the services of (i) (A) through (F) above, is limited to institutional discharge program participants; the limits of (i)(J), above also apply.

Providers of these services must be approved by the Division of Mental Health and Developmental Disabilities. Client Support Services (Supplement 1 to Attachment 3.1-A) are limited to a maximum of 15 hours per month and 180 hours in a calendar year.

(2) Alcohol and Substance Abuse Rehabilitation Services:

(i) For both children and adults who are found in a treatment plan to need substance abuse services:

(A) Assessment and Diagnosis, including psychiatric assessments, psychological testing and evaluation, and psycho-social assessments, to a maximum of four hours per assessment and diagnosis;

(B) Outpatient Services, consisting of individual, group, or family counseling, care coordination, and psychosocial development services, is limited as specified in C-G, below;

(C) Intensive Outpatient Services, a more intensive level of outpatient services for more acute patients, at a minimum of 3 days or evenings per week, 8 hours per week, but not over 12 hours per week for a total of 8 consecutive weeks, unless prior approval is obtained for more hours;

(D) Counseling Services, including individual, group, and family counseling, not to exceed 6 50-minute sessions each in any one month and group therapy not to exceed 4 90-minute sessions in any one month, with an overall aggregate limit for all counseling of 10 sessions per month, to be exceeded only after prior authorization;